Provider Insider

Alabama Medicaid Bulletin — July 2012

The checkwrite schedule is as follows:

07/20/12 • 08/03/12 • 08/17/12 • 09/07/12 • 09/14/12 • 10/05/12 • 10/19/12 • 11/02/12 • 11/16/12 • 12/07/12 • 12/14/12

As always, the release of direct deposits and checks depends on the availability of funds.

New Medicaid Enrollment Requirements for Ordering, Prescribing, and Referring (OPR) Providers

Federal law now requires all physicians and other practitioners who prescribe or order services for Medicaid recipients, or who refer Medicaid recipients to other providers must be enrolled as a Medicaid provider.

As a result of this law, services rendered based on a referral, order, or prescription will be reimbursable **only** if the ordering, prescribing, or referring physician/practitioner is enrolled in the Alabama Medicaid Program.

A new enrollment application was developed for those providers who do not treat Alabama Medicaid recipients for payment, but who do order, prescribe, or refer. These providers will be enrolled as an OPR provider. Medicaid will not make payment to an OPR provider but will recognize their NPI for services rendered by participating Medicaid providers. An abbreviated enrollment application is located on the Alabama Medicaid Agency website at the following link in the Administrative Forms section:

http://medicaid.alabama.gov/CONTENT/5.0 Resources/5.4 Forms Library/5.4.6 Provider Enrollment Forms.aspx.

The application must contain the provider's original signature. The application, along with a copy of the provider's DEA certificate, if applicable, should be mailed to:

HPES Provider Enrollment, P.O. Box 241685, Montgomery, AL 36124

Faxed or emailed copies will not be accepted.

If an OPR provider submits a claim for payment, the claim will deny for error code 1032 (provider type claim input conflict). Medicaid will allow a grace period until September 30, 2012 for OPR providers to become enrolled. On October 1, 2012, claims for services that contain an NPI of an ordering, prescribing, or referring provider not enrolled in Medicaid (either as a participating provider or as an OPR provider) will be denied.

Medicaid encourages all participating providers to be proactive and ensure the ordering, prescribing, referring physician/practitioner is enrolled in Medicaid prior to the October 1, 2012 deadline.

Providers should contact one of the following HPES Provider Representatives with any questions:

- Araceli Wright 1-855-523-9170 extension 2334560
- Remona Riley 1-855-523-9170 extension 2334532
- Shamekia Pena 1-855-523-9170 extension 2334588
- Aleetra Adair 1-855-523-9170 extension 2334587

In This Issue

Pass It On!

Everyone needs to know the latest about Medicaid. Be sure to route this to:

- ❒ *Office Manager*
- ❒ *Billing Department*
- ❒ *Medical/Clinical Professionals*
- ❒ *Other* _____

General Fund Proration

As a result of General Fund proration declared on March 16, 2012, the Alabama Medicaid Agency has been directed to identify and implement cuts to its overall budget. After program impact analysis and multiple provider meetings and communications, the Agency will implement these cuts in three ways:

1) **Reduction of payments to certain provider groups by 10 percent**
   - Physicians
   - Dentists
   - Physician Lab & X-ray
   - Durable Medical Equipment
   - Independent Lab & X-ray
   - Other licensed practitioners
   - Maternity primary contractors (Effective for dates of service on or after May 14, 2012)

2) **Reduction in services to adults (benefits to children remain unchanged)**
   - Change coverage of routine eye exams and work-up for refractive error to once every three years
   - End coverage of eyeglasses as a benefit
   - Limit drugs to one brand-name drug per month; generics and covered OTCs remain unlimited. Allowances will remain for up to 10 brands per month for antipsychotics, antiretrovirals, and switchovers. (In addition to children, LTC recipients are excluded from this reduction.)

3) **Reduction in cough/cold covered drugs for all recipients**
   - Legend generic cough/cold drugs will no longer be covered (legend brand drugs are currently non-covered). Certain OTC drugs will remain covered.

Except as specified otherwise above, these reductions will be effective for dates of service on or after June 1, 2012.

Agency to Begin Re-Enrollment of Providers Starting in July

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

Alabama Medicaid is Preparing for ICD-10 Implementation

ICD-10 planning and preparation is well underway for Alabama Medicaid!

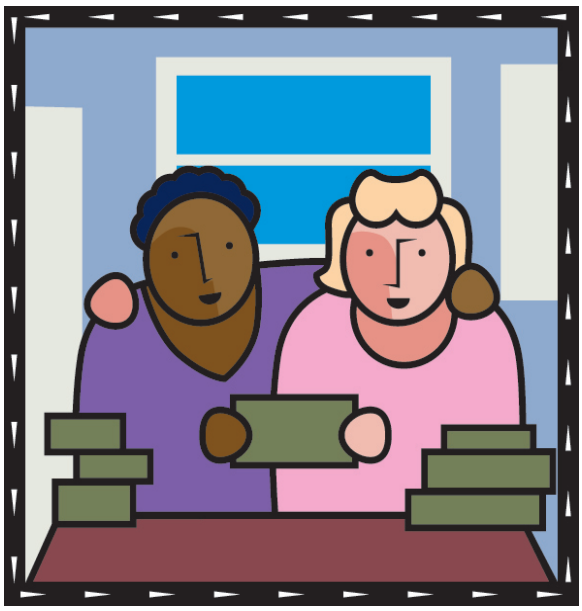
Although, the Centers for Medicare and Medicaid Services (CMS) has proposed a delay in implementation for ICD-10 from October 1, 2013, to October 1, 2014, the Alabama Medicaid is preparing for ICD-10 implementation. We are working with our fiscal agent, HP Enterprise Services, to make the necessary system changes to accommodate ICD-10. We will be using system parameters for the ICD-9 end date and the ICD-10 begin date. Once the proposed rule is finalized, our system parameters will be set accordingly. We are planning for an implementation as early as October 1, 2013, but no later than October 1, 2014.

Our planned system testing is set for early 2013. In order to meet this date, we request that our Alabama Providers and Vendors be prepared to test with us beginning Spring 2013.

Providers and vendors will be selected quarterly to receive and complete surveys related to ICD-10 readiness. If you receive a survey, please take a few moments to complete and return it as this will provide us with information needed to assess readiness and determine the best means of communicating changes and status with you going forward.

More information on our ICD-10 project will be provided in the coming months. Please pay attention to Provider Insiders, RA Banner messages and Alerts related to ICD-10, and be on the lookout for a survey on ICD-10 readiness.

Attention Nursing Home Providers



The Centers for Medicare and Medicaid Services (CMS) has mandated states to develop a process for MDS 3.0 Section Q that requires any nursing facility resident indicating an interest in returning to the community to be given an opportunity for a face-to-face visit with a Local Contact Agency (LCA). CMS has also instructed State Medicaid Agencies to identify a contact for nursing facilities to communicate with when making resident referrals.

The Alabama Medicaid Agency has identified the Alabama Department of Rehabilitation Services as the Local Contact Agency (LCA). Nursing facilities are required to submit Form 431 with the name of the referral to the Local Contact.

Form 431 may be retrieved from the Alabama Medicaid Agency website at *www.medicaid.alabama.gov* under Programs/Long Term Care Services/Resources & Forms/Long Term Care Forms.

If you have any questions, please contact the LCA (ADRS) at 334-293-7011 or *steve.autrey@rehab.alabama.gov.*

Patient 1st Referral Requirements Have Changed

Effective June 1, 2012 the Alabama Medicaid Agency will change Patient 1st Referral requirements to allow PMPs to see patients who are in the process of transferring to their panel without a referral. Once the PMP change becomes official, claims for the previous 60 days from the new PMP will be paid. When a recipient wishes to change their PMP, the change can be made directly by the recipient or made by the new PMP. In the past, the new PMP would have to obtain a referral from the old PMP in order to see the recipient prior to the official change date. PMP changes typically take 15 to 45 days. For example, if a PMP change is requested on June 18 it would become official on August 1. The new PMP will be able to treat the recipient, and claims for dates of service 60 days prior to August 1 will be paid on or after the effective date. These claims will deny prior to the change becoming official.

The new policy will allow the new PMP to both provide services and make referrals. Claims for referrals will also not pay until the PMP change is official. If the change does not become official the claims will not pay without a referral. This could happen if a subsequent change in PMP request is made before the original change is made active. This change does not alter the process or rules for the old PMP. Claims from the old PMP will be paid as normal. The old PMP should no longer be requested to provide referrals for a recipient transferring to other PMPs. Medicaid will monitor PMP changes to ensure that this policy change is not misapplied.

Effective February 22, 2012, patients less than 21 years of age are authorized two (2) pair of glasses, which includes fitting and lenses each year if indicated by an examination.

A prior authorization will be required for subsequent pairs requested in the calendar year. Four new benefits audits will also be implemented with the policy - 6185 lenses, 6186 frames, 6187 exams, and 6188 fittings.

REMINDER ***to all Acute Care Hospitals, Residential Treatment Facilities and Inpatient Psychiatric Hospitals.***

Reporting POAs correctly to Medicaid on the UB-04 claim form:

Reporting Hospital-Acquired Conditions (HAC) and Present on Admission (POA) on the UB-04 Claim Form

Hospital-Acquired Conditions are conditions that are reasonably preventable and were not present or identified at the time of admission; but are either present at discharge or documented after admission. The Present on Admission (POA) Indicator is defined as a set of specified conditions that are present at the time the order for inpatient hospital occurs. Conditions that develop during an outpatient encounter, including the emergency room, observation, or outpatient surgery, are considered POA.

The hospital may use documentation from the physician's qualifying diagnoses to identify POA which must be documented within 72 hours of the occurrence. Medicaid also recommends that the event be reported to Medicaid on the claim or via e-mail within 45 days of occurrence.

It is the responsibility of the hospital to identify these events, report them, and not seek any additional payment for additional days. Medicaid will accept all POA indicators as listed below:

- **Y**-Yes. Diagnosis **was present** at time of inpatient admission.
- **N**-No. Diagnosis **was not present** at time of inpatient admission.
- **U**-No information in the record. **Documentation insufficient** to determine if the condition was present at the time of inpatient admission.
- **W**-Clinically undetermined. Provider **unable to clinically determine** whether the condition was present at the time of inpatient admission.
- **1**-Unreported/Not used. **Exempt** from POA reporting.

If the value code '81' is indicated; then non-covered days must be present and the amount field must be greater than '0'.

It is the hospital's responsibility to include all supporting documentation with the chart for a review to be conducted by Medicaid's contracted Quality Improvement Organization (QIO). Submission of a root cause analysis is not required but may be submitted as part of the documentation to support billing.

Need to Update Third Party Information on a Recipient?

During the eligibility verification process, if it is determined that Medicaid has a Third Party Insurance that is no longer on file, providers can contact the Third Party Division at the Medicaid Agency with a policy cancellation date and request the file be updated.

The most efficient way to contact the Third Party Division is to go to Medicaid's website at:
http://www.medicaid.alabama.gov/CONTENT/6.0_Providers/6.1_Benefit_Coordination.aspx
Select: Update Health Insurance Information, and complete the on-line form to report the change.

Providers may also call the Third Party Division by calling the direct line of the appropriate staff person to update health insurance. Please call the number listed below based on the recipient's last name:

- Recipient's Last Name A through F 334-242-5249
- Recipient's Last Name G through K 334-242-5280
- Recipient's Last Name L through Q 334-242-5254
- Recipient's Last Name R through Z 334-242-5253

REMINDER

Billing Claims for Long Term Care Providers (Completing the UB-04 Claim Form)

- **Home Health Program**
- **Hospice Program**
- **Intermediate Care Facility for the Mentally Retarded Program**
- **Nursing Home Program**
- **Private Duty Nursing Program**

When completing the UB-04 Claim Form, please be mindful that Long Term Care Providers must enter the beginning and ending dates of service billed for the Statement Covers Period.

Additional description and guidelines regarding claim filing are as follows:

- **OUTPATIENT:** Enter the date of service that the outpatient procedure was performed.
- **NURSING HOMES:** Enter the beginning date of service for the revenue code being billed.
- **SPAN BILLING:** When filing for services such as therapies, home health visits, hospice, and private duty nursing within a month, the time period being billed should be entered in form locator FL 6 (Statement Covers Period). In FL 45, the service date should be the first date in the Statement Covers Period. The number of units should match the number of services reflected in the medical record.

Additionally, when billing through the Web Portal, be sure that the header and detail dates contain the same data - both dates must match. Be sure that the detail dates are within the header date span. **Example:** If you are billing one code for the specific date span, the header and detail dates of service must match. In addition, the header dates should not span beyond the period the services were rendered; i.e. do not bill the header date span for the entire month when home health services were only rendered on the 12th of the month.

For Nursing Home claims regarding patient days, Medicaid covers the day of admission, but not the day of discharge.

For questions regarding billing procedures, please contact HP Provider Assistance at (800) 688-7989.

Cascading Referrals

A cascading referral is used in situations where more than one consultant may be needed to provide treatment for an identified condition(s). When this situation arises, the original referral form is generated by the assigned primary medical provider.

If the first consultant determines a recipient should be referred to another consultant/specialist, it is the first consultant's responsibility to provide a copy of the referral form to the second consultant. This process is continued until the condition(s) have been rectified or in remission, or referral expires, at which time a new screening and referral must be obtained. A new approval/EPSDT screening must be provided anytime the diagnosis, plan of care, or treatment changes. The consultant must contact the PMP for a new referral/screening at that time.

The appropriate block to mark on the referral form for a cascading referral is labeled: "Referral to other provider for identified condition (cascading referral)."

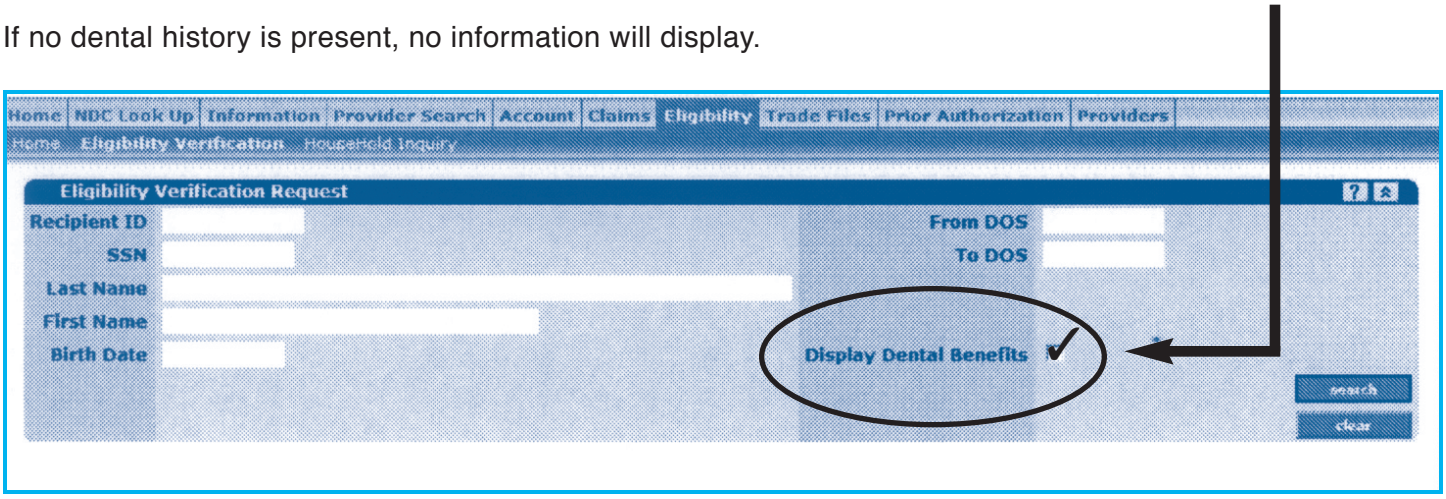
All consultants should furnish written results of findings to the referring provider or PMP promptly. Patient 1st and EPSDT providers are responsible for appropriate referrals and follow-up.

If you have any questions regarding cascading referrals, you may contact Toni Hopgood at 334-353-4724 or Gloria Wright at 334-353-5907.

Attention Dental Providers

In order to obtain dental history during the eligibility verification process on the web portal, the "Display Dental History" box must be checked. If this box is not checked, the system will not return any data.

If no dental history is present, no information will display.



If no dental history is present, no information will display.

To verify eligibility, select the eligibility tab and choose eligibility verification. Providers may search for eligibility using any of the following combinations:

1. Enter the Medicaid number and the From DOS & To DOS.
2. Enter the First & Last Name, date of birth, and the From DOS & To DOS.
3. Enter the social security number, date of birth, and the From DOS & To DOS.

Once the eligibility screen displays, the dental history will show at the very bottom of the screen.

Provider Electronic Solutions Upgrade Now Available

Version 3.01 of the Provider Electronic Solutions software, upgrade and full install along with the billing manual, can be downloaded from the Medicaid website at *www.medicaid.alabama.gov*. Click 'providers,' then click 'provider electronic solutions software,' and scroll down to the bottom of the page to the software download section. When applying the 3.01upgrade, your current version must be 3.00. For further assistance, or to request the software on CD, contact the EMC helpdesk at 1-800-456-1242 or e-mail address: *alabamasystemsemc@eds.com*.

The 3.01 version of the software contains the following changes:

Professional Claim Form -
Users can select a 'blank' or a 'P' for the Patient Signature Indicator field.

List Builder Forms -
Users can enter up to 10 digits in the Carrier ID code field on the Carrier or Policyholder List builder forms.

Inpatient Claim Form -
On Header 1, users can enter a 'from date of service' that is up to 3 days prior to the 'admit date' on Header 5.

NCPDP Batch Responses -
When a pharmacy claim is denied for other insurance, detailed information related to the other insurance is displayed.

Remember, users **MUST** be at version 3.00 before attempting to upgrade to 3.01.

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Provide Assistance for:

- Ambulance
- Ambulatory Surgical Centers
- CRNA
- Chiropractors
- Dental
- DME
- EPSDT (Physicians)
- ESWL
- Free Standing Radiology
- FQHC
- Hearing Services
- Waiver Services
- Home Health
- Hospice
- Hospital
- Independent Labs
- Maternity Care
- Mental Health
- Nursing Home
- Nurse Midwives
- Nurse Practitioners
- Opticians
- Optometrists
- PEC
- Personal Care Services
- Physicians
- Podiatrists
- Prenatal Clinics
- Private Duty Nursing
- Public Health including:
  - Elderly and Disabled Waiver
  - Home and Community Based Services
  - EPSDT
  - Family Planning
  - Prenatal
  - Preventive Education
- Rehabilitation Services
  - Home Bound Waiver
  - Therapy Services (OT, PT, ST)
  - Children's Specialty Clinics
- Renal Dialysis Facilities
- Rural Health Clinic
- Swing Bed

2012 State Checkwrite Schedule

~~01/06/12~~	~~04/06/12~~	07/06/12	10/05/12
~~01/20/12~~	~~04/20/12~~	07/20/12	10/19/12
~~02/03/12~~	~~05/04/12~~	08/03/12	11/02/12
~~02/17/12~~	~~05/18/12~~	08/17/12	11/16/12
~~03/02/12~~	~~06/08/12~~	09/07/12	12/07/12
~~03/16/12~~	~~06/22/12~~	09/14/12	12/14/12

The release of funds is normally the second Monday after the RA date. Please verify direct deposit status with your bank. Go to *www.medicaid.alabama.gov* to view the payment delay update details. Payment alerts will be posted only if there will be a payment delay. As aways, the release of direct deposits and checks depends on the availability of funds.

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